IDAHO DEPARTMENT OF
HEALTH & WELFARE

COPY

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BUREAU OF FACILITY STANDARDS
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March 17, 2010

Susan Broetje
Idaho State School And Hospital
1660 Eleventh Avenue North
Nampa, ID 83687

Provider #13G001

Dear Ms. Broetje:

On **March 15, 2010**, a complaint survey was conducted at Idaho State School And Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004552

Allegation: Individuals are not properly assessed following restraint.

Findings: An unannounced onsite complaint investigation was conducted from 3/11/10 - 3/15/10. During that time, review of Team Investigation and Action Plans, review of restraint records, and individual interviews were conducted with the following results:

The facility's Team Investigation and Action Plans, dated 12/17/09 - 3/11/10, were reviewed. This form was used to document injuries during restraint. One of the 51 records reviewed, dated 1/3/10, documented an injury occurred during a restraint. Nursing notes corresponding with the injury documented vital signs were taken and neurological checks were completed.

Additionally, a second individual's record contained documentation of a restraint on 3/3/10. The record documented no injury during the restraint. The individual's nursing notes were also reviewed and did not document injury received during restraint.

Additionally, one of the above individuals who had been restrained was interviewed on 3/12/10. The individual stated any issues regarding restraint had been resolved and he had no concerns.

Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As the complaint was not substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

MICHAEL A. CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/mlw

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March 17, 2010

Susan Broetje
Idaho State School And Hospital
1660 Eleventh Avenue North
Nampa, ID 83687

Provider #13G001

Dear Ms. Broetje:

On **March 15, 2010**, a complaint survey was conducted at Idaho State School And Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004565

Allegation #1: Individuals are subjected to continued and ongoing psychological abuse, and the facility is not taking steps to prevent recurring psychological abuse.

Findings: An unannounced onsite complaint investigation was conducted from 3/11/10 - 3/15/10. During that time, review of investigations, record review, and individual and staff interviews were conducted with the following results:

The facility investigations were divided into two categories - allegations directed towards staff and allegations between individuals residing at the facility. Allegations between individuals residing at the facility were investigated through a Team Investigation and Action Plan form.

The facility's Team Investigation and Action Plans, dated 12/17/09 - 3/11/10, were reviewed. Of the 51 documents, 7 identified individuals who had repeatedly been the victim of psychological assault by other individuals residing at the facility, and 2 identified individuals who had repeatedly been the perpetrator of psychological assault towards other individuals residing at the facility. All incidents of psychological assault occurred on two living units at the facility.

The incidents described included name calling, use of foul language and derogatory terms directed at the individual or their family, threats of harm, etc. All forms documented individuals were separated during the altercations.

Thirteen direct care staff were interviewed on 3/11/10 and 3/12/10. All 13 staff stated incidents of name calling, threats, and derogatory comments between individuals residing at the facility were documented as psychological assault. All 13 staff stated they were to separate individuals when incidents occurred, problem solve as needed, ensure physical safety, encourage individuals to use coping skills, and notify the Administrator on Duty.

Eight individuals residing at the facility, who had been victims of documented psychological assault, were interviewed. All 8 stated they had not been harmed by the name calling, derogatory remarks, or threats that had been made to them. All 8 stated the incidents had no negative impact on them.

The Administrator, Program Director, and Administrative Services Manager were all interviewed, on 3/12/10 from 2:20 - 3:05 p.m. All stated incidents of name calling, threats of harm, and derogatory remarks towards an individual or their family were documented as psychological assault. The Administrator on Duty was notified of all incidents, and the facility used the information gathered in the documentation of incidents to assess interventions and their effectiveness.

The State Operations Manual, Appendix J, Survey Procedures and Interpretive Guidelines for Intermediate Care Facilities for Persons with Mental Retardation, defines psychological abuse as incidents including, but not limited to, "humiliation, harassment, and threats of punishment or deprivation, sexual coercion, intimidation, whereby individuals suffer psychological harm or trauma."

In summary, although incidents of name calling, use of foul language and derogatory terms directed at the individual or their family, threats of harm, etc., were being documented by the facility, the incidents did not meet the definition of psychological abuse as the individuals involved did not indicate harm.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Staff accused of abuse and neglect are allowed to have ongoing contact with individuals residing at the facility during the investigative process.

Findings: An unannounced onsite complaint investigation was conducted from 3/11/10 - 3/15/10. During that time, review of investigations, the facility's policy and procedure for abuse, neglect and mistreatment, and staff interviews were conducted with the following results:

The facility's policy for Abuse Prevention, dated 2/1/10, stated "The accused perpetrator should either be removed from client contact (i.e. put on administrative leave or on alternate duty with no client contact), or be reassigned to another unit under the direction of the supervisor or charge person until the investigation is complete."

The facility's investigations, from 12/17/09 - 3/11/10, were reviewed and documented the following:

The facility had conducted 14 investigations for abuse, neglect and mistreatment. Of the 14 investigations, 10 contained allegations of staff abuse or neglect towards individuals residing at the facility. Four of those 10 investigations documented staff were suspended from duty pending the outcome of the investigations. The remaining 6 investigations documented staff were reassigned or prevented from client contact as follows:

- 4 were reassigned to other units.
- 1 was scheduled for vacation during the investigation.
- 1 was initially reassigned to another unit, then suspended the following day.

The Administrator was interviewed on 3/12/10 from 2:20 - 3:05 p.m. The Administrator stated if a staff was accused of an action that would cause direct harm to an individual, such as physical abuse, the staff would be suspended from work during the investigation. However, if the allegation was something that would not necessarily put another individual at risk, such as name calling or failing to follow a particular individual's enhanced supervision guidelines, the staff would be transferred to a different unit under the direct supervision of the unit supervisor or charge person. The Administrator stated all administrative and supervisory staff were provided clear direction during training on the policy with regards to supervision expectations and requirements.

Further, the Administrator stated one individual had been mistakenly transferred to another unit following an allegation of physical abuse. However, the incident was identified by administrative staff the following day and the individual was suspended from duty.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

MICHAEL A. CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
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